STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175506	A. BUILDING _____ B. WING _____	08/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANDBE HOME, INC	201 W CRANE ST NORTON, KS 67654

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey and Complaint Investigation # 68059.	F 000		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This Requirement is not met as evidenced by:	F 157		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 157	Continued From page 1 The facility had a census of 70 residents.The sample included 11 residents. Based on observation, interview and record review the facility failed to notify the physician or responsible party for changes in the residents treatment and or condition for 2 of the 11 residents sampled. (# 8, # 25) Findings included: - Resident # 8's quarterly Minimum Data Set 3.0 assessment (MDS), dated 7/15/13, indicated the resident's Brief Interview for Mental Status (BIMS) score was 15 which indicated the resident was cognitively intact. Further review of the MDS revealed the resident needed supervision with personal hygeine, and uses walker or wheelchair for mobility. Review of the medical record revealed the resident had a urinalysis test and culture of his/her urine on 8/12/13. On 8/14/13 the lab results of the urine culture indicated the resident had Methicillin Resistant Staphylococcus Aures (MRSA). (A resistant infection) On 8/14/13, the physician ordered Bactrim (an antibiotic) DS, one tablet, po (by mouth), 2 times a day for 10 days. The progress notes, dated 8/15/13, indicated the Bactrim was not available and was not administered to the resident as ordered by the physician. The progress notes, dated 8/16/13, indicated the resident was administered his/her first dose of Bactrim at 11:25 AM. (2 days after the physician order) Further review of the medical record indicated the staff had not notified the resident's	F 157		

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F 157	Continued From page 2 physician the medication was not started on the day it was ordered. Review of the resident's medication card revealed the medication card was dispensed on 8/16/13. (2 days after the physician order) On 8/20/13 at 11:30 AM, the resident was observed seated in his/her wheelchair in the north hallway outside of his/her room. On 8/21/13 at 1:35 PM, Staff Nurse B verified when the facility receives a physician order the pharmacy is notified and the medication is ordered for the resident and should be started as soon as the medication arrives at the facility. On 8/21/13 at 2:00 PM, Administrative Nurse A verified the Bactrim was not adminstered to the resident on the day the physician had ordered the medication and the medication should have been adminstered to the resident on the same day as ordered by the physician. The 4/18/13, Nursing Facility Resident Rights, stated the facility is to notify the physician and or legal representative of any change with the resident within 24 hours. The facility failed to notify the physician the resident had not received his/her medication as ordered.	F 157		

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F 157	Continued From page 3	F 157		

- Resident #25's quarterly (MDS) Minimum Data Set 3.0 assessment, dated 8/5/13, indicated the resident had a (BIMS) Brief Interview for Mental Status score of 15, which indicated the resident's cognition was intact. The MDS revealed the resident was independent with setup assistance of 1 staff for bed mobility, walk in room, toileting, personal hygiene, and supervision with 1 staff assistance for transfers. The MDS further revealed the resident had 2 falls without injury on the prior assessment.

The 8/8/13 care plan indicated the resident had a personal alarm while in bed and the staff were to check placement and functioning throughout the night.

On 6/2/13 at 1:55 AM, nurse's note indicated the resident was on the floor by his/her bed, the resident was getting up to go to the bathroom. The nurse's note further indicated the physician was notified by fax.

Review of the resident's medical record revealed no documentation the family had been notified of the resident's fall on 6/2/13.

On 6/9/13 at 2:10 AM, nurse's note indicated the resident had called for help and was on the floor next to his/her bed. The nurse's note further indicated the physician was notified by fax.

Review of the resident's medical record revealed no documentation the family had been notified of

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F 157	Continued From page 4 the resident's fall of 6/9/13. On 8/21/13 at 10:50 AM, observation revealed the resident seated in his/ her recliner reading the newspaper. On 8/21/13 at 10:35 AM, Nurse Aide E stated the resident has an alarm when in bed because that is when his/her falls occur. On 8/21/13 at 3:00 PM, Nurse D stated the resident's family and physician are to be notified when he/she has a fall. On 8/22/13 at 10:44 AM, Nurse A verified the staff are to notify the family after the resident has a fall. The facility's 4/18/13 Resident Right policy stated the facility will notify the attending physician, and legal representative within 24 hours of an accident. The facility failed to notify Resident #25's legal representative of two falls.	F 157		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This Requirement is not met as evidenced by: The facility had a census of 70 residents. The sample included 11 residents which 3 were	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 323	Continued From page 5	F 323		

reviewed for accidents. Based on observation, record review and interview, the facility failed to ensure the resident ' s environment remain as free of accident hazards as possible and that each resident receive adequate assistance devices to prevent accidents for 1 of 3 residents reviewed for accidents. (#48)

Findings included:

- Resident 48 ' s quarterly (MDS) Minimum Data Set 3.0 assessment, dated 7/29/13, indicated the resident had short and long term memory loss, and severely impaired cognition. Further review of the MDS revealed the resident required extensive assistance of 2 staff members for bed mobility, transfers, dressing, toileting, and personal hygiene. The MDS indicated the resident did not have any range of motion impairment.
The 7/30/13 care plan, directed the staff to use 1-2 person assist for transfers and toileting and the resident is to use a broda chair (a positioning chair) for mobility.
The 7/23/13 restorative therapy initial evaluation note stated the resident was minimal assistance for bed mobility and transfers and the resident received active range of motion 3-5 times a week.
On 8/21/13 at 9:06 AM, observation revealed Nurse Aide E and Nurse Aide J assisting the resident with toileting. The staff had placed a transfer belt (a device used to transfer people from one position to another) around the resident ' s waist which both nurse aides took ahold of each side and assisted the resident to stand and pivot to the toilet. The resident ' s legs buckled and the resident did not bear any weight. The nurse aides continued to hold up the resident as Nurse Aide E used 1 hand to pull up the residents skirt and Nurse Aide J used 1 hand to pull down the resident ' s brief. The nurse aides then placed

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F 323	Continued From page 6	F 323		

the resident on the toilet. Nurse Aide E instructed the resident to " hug " him/her to assist the resident to stand. The resident ' s legs buckled, causing Nurse Aide E to hold the resident up while Nurse Aide J attempted to provide pericare. The resident was placed into the broda chair and Nurse Aide E again assisted the resident to stand by holding on to the transfer belt and Nurse Aide J finished providing pericare and then placed the resident in the broda chair.
On 8/21/13 at 11:02 AM, observation revealed Nurse Aide E and Nurse Aide J assisting the resident from the bed to the resident ' s commode. ,Nurse Aide J placed a transfer belt onto the resident and instructed him/her to hold on. The resident ' s legs buckled and Nurse Aide J held the resident up while Nurse Aide E performed pericare. The resident was placed back on to the commode. Nurse Aide J again assisted the resident to stand but the resident ' s legs buckled and Nurse Aide J held on to her to allow Nurse Aide E to perform pericare on the resident. The resident was again placed into the broda chair with his/her hips off to the left side. Nurse Aide J assisted the resident up again, holding on to the transfer belt and Nurse Aide E adjusted the resident ' s clothing and positioned him/her straight into the broda chair.
On 8/21/13 at 3:15 PM, observation revealed Nurse Aide K placed a transfer belt on the resident. Nurse Aide K and Nurse Aide L stood on each side of the resident and placed their arms under the resident ' s arms and held onto the transfer belt handles. The resident was assisted to stand but the resident ' s legs buckled. The nurse aides held the resident up and placed him/her on the commode. The resident was assisted up but did not stand and Nurse Aide L was attempting to do pericare but could not reach the wipes and they had to sit the resident back

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F 323	Continued From page 7 down on the commode. The resident was again assisted up by both staff, pericare provided and the resident was placed in the broda chair. On 8/21/13 at 3:29 PM, Nurse Aide L stated the resident ' s legs do buckle but stands better when more awake. On 8/21/13 at 9:21 AM, Nurse M stated the resident will pull up his/her feet and other times will stand. On 8/21/13 at 2:40 PM, Nurse A stated residents are evaluated by physical therapy and if the resident is not able to bear weight, they are expected to use a lift. On 8/21/13 at 4:21 PM, Nurse N stated he/she looks at the computer and it will tell him/her how the staff are transferring the resident. Physical Therapy needs to evaluate the resident to see how he/she is transferring. If the resident is unable to bear weight, the staff would need to use a lift on the resident. The 8/9/02 Facility Lifting and transferring policy stated the facility is committed to the prevention of injury to staff and residents through the use of a no lift program. The facility policy also states the staff are to comply with the no lift policy at all times. The Stand Lift is to be used if the resident cannot bear weight for 5 seconds and strength in at least one arm and one leg. The full body lift is to be used if the resident cannot assist in transfers or positioning. The facility failed to ensure the resident ' s environment remain as free of accident hazards as possible and that each resident receive adequate assistance devices to prevent accidents to 1 of 3 resident reviewed for accidents. (#48)	F 323		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any	F 329		

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F 329	Continued From page 8 drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This Requirement is not met as evidenced by: The facility had a census of 70 residents.The sample included 11 residents. Based on observation, interview and record review the facility failed to ensure the resident's drug regimen was free form unnecessary medications for 1 of the 11 sampled residents. (# 8) Findings included: - Resident # 8's quarterly Minimum Data Set 3.0 assessment (MDS), dated 7/15/13, indicated the resident's Brief Interview for Mental Status (BIMS) score was 15 which indicated the resident was cognitively intact. Further review of the MDS revealed the resident needed supervision with	F 329		

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F 329	Continued From page 9	F 329		

personal hygiene and uses a walker or wheelchair for mobility.

Review of the medical record revealed the resident had a urinalysis test and culture of his/her urine on 8/12/13. On 8/14/13 the lab results of the urine culture indicated the resident had Methicillin Resistant Staphylococcus Aures (MRSA). (A resistant infection)

On 8/14/13, the physician ordered Bactrim (an antibiotic) DS, one tablet, po (by mouth), 2 times a day for 10 days.

The progress notes, dated 8/15/13, indicated the Bactrim was not available and was not administered to the resident as ordered by the physician.

The progress notes, dated 8/16/13, indicated the resident was administered his/her first dose of Bactrim at 11:25 AM. (2 days after the physician order) Further review of the medical record indicated the staff had not notified resident's physician the medication was not started on the day it was ordered.

Review of the resident's medication card revealed the medication card was dispensed on 8/16/13. (2 days after the physician order)

On 8/20/13 at 11:30 AM, the resident was observed seated in his/her wheelchair in the north hallway outside of his/her room.

On 8/21/13 at 1:35 PM, Staff Nurse B verified when the facility receives a physician order the pharmacy is notified and the medication is ordered for the resident and should be started as soon as the medication arrives at the facility.

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F 329	Continued From page 10 On 8/21/13 at 2:00 PM, Administrative Nurse A verified the Bactrim was not adminstered to the resident on the day the physician had ordered the medication and the medication should have been adminstered to the resident on the same day as ordered by the physician. The 4/18/13, Nursing Facility Resident Rights, stated the facility is to notify the physician and or legal representative of any change with the resident within 24 hours. The facility failed to ensure the Resident # 8's drug regimen was free from unnecessary drugs.	F 329		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This Requirement is not met as evidenced by: The facility had a census of 70 residents. The sample included 11 residents. Based on observation, interview and record review the facility failed to prepare, distribute and serve food under sanitary conditions for the 70 residents who reside in the facility. Findings included: - On 8/19/13 at 11:52 AM, observation revealed, Dietary Staff H had long strands of hair hanging out from his/her hairnet on both sides of his/her	F 371		

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F 371	Continued From page 11 neck. Continued observation revealed, Dietary staff I wearing a baseball cap, with hair hanging below the cap, loading soiled dishes into the dishwasher and ambulating throughout the kitchen. On 8/21/13 at 11:21 AM, observation revealed Dietary Staff G preparing lemonade in the kitchen, with his/her hair hanging out both sides and back of the hairnet. On 8/21/13 at 11:21 AM observation revealed, Dietary Staff H pouring salad dressing into the dispensers and preparing lunch trays, with his/her bangs out of the front of his/her hairnet and long pieces of hair hanging out both sides. On 8/21/13 at 1:45 PM, Dietary Staff F verified all dietary staffs ' hair should be secured within a hairnet or cap. Dietary Staff F further stated if the hair was hanging out below the cap, the dietary staff should wear a hairnet also. Review of the Dietary Procedure Policy, dated 1/21/13, stated hair is to be clean and covered with a hairnet or cap. It also states that straight or flyaway hair, shoulder length or longer, must be tied back and hairnets worn by all personnel. The facility failed to prepare, distribute and serve food under sanitary conditions for the 70 residents who receive food from the facility ' s kitchen.	F 371		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 441	Continued From page 12 transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This Requirement is not met as evidenced by: The facility had a census of 70 residents. The sample included 11 residents. Based on observation, record review and interview, the facility failed to provide necessary infection control practices for 10 of the 20 residents who received oxygen.	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 441	Continued From page 13 - On 8/19/13 at 11:05 AM, during the initial tour, observation revealed nasal canulas placed on top of the oxygen concentrator, without a protective cover, for the following residents: #53, #28, #10, #25, #48, #59. On 8/21/13 at 8:24 AM, observation revealed a nasal canula sitting on top of the oxygen concentrator, without a protective cover, for Resident #48. On 8/21/13 at 10:01 AM, observation revealed a nasal canula sitting on top of the oxygen concentrator, without a protective cover, for Resident #59. On 8/22/13 at 8:25 AM, observation revealed a nasal canulas placed on top of the oxygen concentrator, without a protective cover, for the following residents: #53, #28, #20, #11, #9. On 8/22/13 at 8:25 AM, observation revealed a nasal canula wrapped around the positioning quarter rail of his/her bed, without a protective cover, for Resident #40. On 8/22/13 at 8:25 AM, observation revealed a nasal canula hanging off the side of the oxygen concentrator, without a protective cover, for Resident #10. On 8/22/13 at 8:25 AM, observation revealed a nasal canula hanging off the side of the oxygen concentrator and touching the floor, without a protective cover, for Resident #25. On 8/22/13 at 9:58 AM observation revealed Resident #10 had a nebulizer mask not in use, stored on the bedside table without a protective	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175506	A. BUILDING _____ B. WING _____	08/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANDBE HOME, INC	201 W CRANE ST NORTON, KS 67654

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 14 cover. On 8/22/13 at 10:55 AM, Nurse A verified oxygen tubing and nasal canulas are to be stored in plastic bags when not in use. Nurse A also verified that nebulizer masks are to be rinsed out, washed and stored as soon as the treatment was complete. On 8/22/13 at 10:59 AM, Nurse B verified that oxygen tubing and nasal canulas are to be stored in plastic bags and put in the resident's drawer in their room when not in use. Review of the facility's Drug Nebulization Therapy policy instructs staff at the end of each treatment to disassemble nebulizer and mouthpiece, thoroughly rinse parts under hot, soapy tap water, rinse with water, shake off excess water, and placed on a paper towel to air dry. The facility failed to practice infection control practices for 10 of the 20 residents who received oxygen.	F 441		